

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 1 1957

318

State File No. 37767
1003 Registrar's No. 10031

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>2 mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Chronic Hosp</u>			STREET ADDRESS (If rural, give location) <u>4220 Westminster</u>		
3. NAME OF DECEASED (Type or Print) <u>Earl</u>		b. (Middle) _____		c. (Last) <u>Logan</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>		8. DATE OF BIRTH <u>9-7-1897</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Arkansas</u>		9. AGE (In years last birthday) <u>60</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John P. Logan</u>		13b. MOTHER'S MAIDEN NAME <u>Nina Saltenberger</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Nil</u>		17. INFORMANT'S SIGNATURE OR NAME <u>John Logan, 525 W. Odgen, Hinsdale, Ill.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Epidermoid C.A. of Mesopharynx</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>146x</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Tracheostomy + Gastrostomy - C.A. Epidermoid</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>8-9-57</u> , 19 <u>57</u> , to <u>10-25-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-25-57</u> , 19 <u>57</u> , and that death occurred at <u>10:20 a.m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>John M. Beckham, M.D.</u>		(Degree or title) _____		23b. ADDRESS <u>5800 Arsenal St.</u>	
23c. DATE SIGNED <u>10/25/57</u>		23d. LOCATION (City, town, or county) (State) <u>Fort Smith, Arkansas.</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10-25-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	
24d. DATE REC'D BY LOCAL REG. <u>OCT 26 57</u>		24e. REGISTRAR'S SIGNATURE <u>J. Earl Smith - md</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>	
24f. ADDRESS _____		25. ADDRESS <u>4700 Washington Blvd.,</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Stanley H. Dixon

Licensed Embalmer No. 419

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.